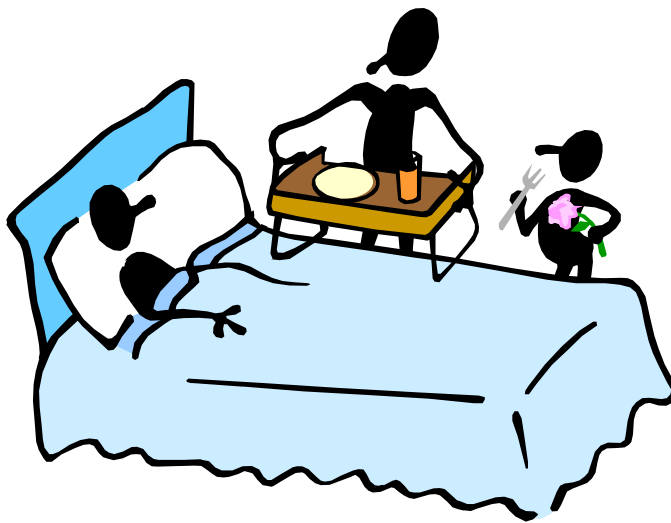


# **SOUTH DAKOTA MEDICAID PROGRAM**



## **HOSPICE PROVIDER BILLING MANUAL**

# **South Dakota Medical Assistance Hospice Care Services**

## **Introduction**

Hospice is an optional benefit that South Dakota has chosen under its Medical Assistance Program. Hospice provides health care and support services to a terminally ill Medicaid or dually eligible recipient and to the recipient's family. Recognizing the impending death, hospice care is an approach to treatment focusing on palliative rather than curative care. Hospice care includes attending to the emotional, spiritual, social and medical needs of the terminally ill recipient and the family. The hospice provider seeks to help the recipient and the family to come to terms with the terminal condition and help the recipient live the remaining days of life as comfortably, functionally and normally as possible.

## **Providers**

A hospice may enroll as a Medicaid provider if licensed as a hospice provider by the Department of Health, meets Medicare conditions of participation and has an approved Medical Assistance provider agreement. Hospice provided to dually eligible recipients must be provided first in accordance with Medicare policies, rules, regulations and guidelines and second by the policies set forth in the State Medicaid Manual.

## **Hospice Care Eligibility Requirements**

- A recipient must be certified as terminally ill to be eligible for coverage of hospice care. Hospice care may continue until a recipient is no longer certified as terminally ill or until the recipient or a representative revokes the election of hospice.
- A recipient may live in a home in the community or in a long-term care facility while receiving hospice services.
- A dually eligible recipient must elect or revoke hospice care simultaneously under both the Medicare and the Medicaid programs.

## **Physician Certification**

A written certification statement, signed by the medical director of the hospice or a physician member of the hospice interdisciplinary group and the recipient's attending physician should be obtained within two calendar days after hospice care is initiated. If the hospice does not obtain a written certification within two calendar days after hospice care is initiated, a verbal certification must be obtained within the two calendar days and a written certification must then be obtained no later than 8 days after care is initiated. If the certification requirements are not met, no payment can be made for hospice care provided prior to the date of any subsequent certification. The certification statement must include a statement indicating the recipient's medical prognosis is a life expectancy of six months or less.

## **Election of Hospice Care**

- A. A recipient who is eligible for hospice care and who wishes to elect hospice care must sign an election statement. The election statement must include:
1. The name of the hospice providing care.
  2. An acknowledgment that the recipient understands that hospice provides palliative, not curative care for the terminal illness.
  3. An acknowledgment that the recipient waives all rights to Medicaid payments for the duration of the election of hospice care for the following services:
    - a. Hospice care provided by a hospice other than the hospice designated in (1) unless the care is provided under arrangement made by the designated hospice.
    - b. Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected; a related condition; or equivalent to hospice care except for services:
      - Provided directly or under arrangement by the designated hospice.
      - Provided by the recipient's attending physician if the physician is not an employee of or receiving compensation from the designated hospice.
      - Provided as room and board by a nursing facility or ICF/MR if the recipient is a resident of the facility.
  4. The effective date of the election.
  5. The signature of the recipient.
- B. A legal representative of the recipient may act on behalf of the recipient in all matters pertaining to hospice care.

## **Revocation of Election of Hospice Care**

- A recipient may revoke the election of hospice care at any time by signing and dating a revocation statement that indicates the effective date of the revocation of hospice care. The effective date of the revocation must be on or after the date the form is signed.
- After revoking the election, a recipient may receive any of the Medicaid benefits they waived by choosing hospice care.
- A recipient may elect hospice again at any time if they are eligible for hospice care benefits.

## **Change of Designated Hospice Provider**

A recipient may change the designation of the hospice provider from which the recipient chooses to receive care. A change of the designated hospice provider is not a revocation of the election. The recipient must sign a statement indicating the name of the hospice provider from which the recipient was receiving care, the name of the newly designated hospice provider and the effective date of the change. A copy of the statement must be maintained by both hospice providers.

## **Notification to the Department**

- A. A statement of certification, election, or revocation of election should be sent to the department within two working days after the hospice provider obtains the signed statement from the recipient. Payment for hospice services will not be made until the appropriate documentation has been received by the department.
- B. Each hospice provider is to design and print its own statements of certification, election and revocation of election. For recipients dually eligible for Medicare and Medicaid, the statements used for Medicare may be used if appropriate references to Medicaid are included; for example, an election form should include a statement acknowledging the recipient waives Medicaid as well as Medicare benefits.

## **Developing a Plan of Care**

- A. An interdisciplinary team must assess a recipient's needs and develop a written plan of care before services can be provided. Services provided by the hospice must be consistent with the plan of care and must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.
- B. At least two members of the interdisciplinary team must be involved in the development of the initial plan of care, and one of these individuals must be a nurse or physician. The other members of the interdisciplinary team must review and provide input to the plan of care within two working days following the day of assessment.

## **Covered Services**

The hospice must provide the services listed. Core services must routinely be provided directly by hospice employees. The hospice may contract for supplemental services provided during periods of peak patient load or for extraordinary circumstances. All services must be performed by appropriately qualified personnel.

- A. Core Services
  - 1. Nursing services provided by or under the supervision of a registered nurse.
  - 2. Social services provided by a social worker under the direction of a physician.

3. Services performed by a physician, dentist, optometrist, or chiropractor.
4. Counseling services provided to the recipient and family member or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided to train the recipient's family or caregiver to provide care and help the recipient, family members and caregivers adjust to the recipient's approaching death.

**B. Supplemental Services**

1. Inpatient hospice care including procedures necessary for pain control or acute or chronic symptom management.
2. Inpatient respite care.
3. Medical equipment, supplies and drugs. Medical equipment including self help and personal comfort items related to the palliation or management of the recipient's terminal illness must be provided by the hospice for use in the recipient's home. Medical supplies include supplies specified in the written plan of care. Drugs include those used to relieve pain and control symptoms for the recipient's terminal illness.
4. Home health aide services and homemaker services which include personal care services and household services, such as changing a bed, light cleaning and laundering, necessary to maintain a safe and sanitary environment in areas of the home used by the recipient. Aide services must be provided under the supervision of a registered nurse.
5. Physical therapy, occupational therapy and speech and language pathology services provided for symptom control or to maintain activities of daily living and basic functional skills.

**Payment for Hospice Services**

- A. The hospice provider is paid at one of four predetermined rates for each day a recipient is under the care of the hospice. The four rates exclude payment for physician services that are paid separately under the physician's individual provider agreement. The Medicaid program uses the rates established by Medicare for payment of Part A hospice benefits to pay Medicaid hospice services on a prospective bases.

- B. The hospice provider is paid an amount applicable to the type and intensity of services provided each day to the recipient. The four levels of care into which each day of care is classified are:
1. Routine Home Care. This level of care is used for each day the recipient is under the care of the hospice and the recipient is not classified at another level of care. This level of care is paid without regard to the volume or intensity of services provided.
  2. Continuous Home Care. This level of care is used for each day the recipient receives nursing services on a continuous basis during a period of crisis in the recipient's home. The hospice is paid an hourly rate for every hour of continuous home care furnished up to a maximum of 24 hours a day.
  3. Inpatient Respite Care. This level of care is for each day a recipient is in an inpatient facility and receiving respite care. Payment for inpatient respite care is limited to 5 consecutive days beginning with the day of admission but excluding the day of discharge. Any inpatient respite care days in excess of 5 consecutive days must be billed as routine home care. Inpatient respite care may not be paid when a recipient resides in a long-term care facility.
  4. General Inpatient Care. This level of care is for each day the recipient receives inpatient hospice care in an inpatient facility for control of pain or management of acute or chronic symptoms that cannot be managed in the home. The day of admission to the facility is general inpatient care and the day of discharge is not general inpatient care, unless the recipient is discharged deceased. Payment for general inpatient care may not be made to a long-term care facility when that facility is considered the recipient's home; however, payment for general inpatient care can be made to another long-term care facility.
- C. Payments for inpatient care days will be limited according to the number of inpatient care days furnished to medical assistance recipients by the hospice in a year. The maximum number of payable inpatient respite and general inpatient days may not exceed twenty percent of the total number of hospice care days provided to all medical assistance recipients by the hospice. If the maximum number of days exceeds twenty percent of total days, an adjustment will be made to pay the excess days at the routine home care rate and the difference will be recovered from the hospice provider. The limitation on inpatient care days does not apply to recipients diagnosed with acquired immunodeficiency syndrome (AIDS).

### **Payment for Physician Services**

- A. The daily rates paid for hospice care include payment for the administrative and general supervisory activities performed by the medical director or a physician member of the interdisciplinary team. These activities include participation in establishment of care plans, supervision of care and services, periodic review and updating of care plans, and establishment of governing policies. The cost of these activities may not be billed separately.

- B. The hospice may be paid at the current Medicaid rate for physician services provided for purposes other than those listed above if the physician is an employee of the hospice or provides services under arrangement with the hospice. Payment is not available for donated physician services.
- C. Payment may be made for personal professional services provided by a recipient's attending physician, if the physician is not an employee of the hospice, not providing services under arrangement with the hospice, or does not volunteer services to the hospice. Costs for services other than personal professional services, such as lab or x-ray, may not be included on the attending physician's bill and may not be billed separately.

### **Room and Board Payment for Recipient in Long-Term Care Facility**

- A. When hospice care is furnished to a recipient residing in a long-term care facility, payment to the long-term care facility by the Medicaid program is no longer available and the hospice is responsible for paying the room and board furnished by the long-term care facility. A room and board payment equal to 95% of the Medicaid rate payable to the long-term care facility at the time the services are provided will be made to the hospice. The hospice may not negotiate a room and board rate with the long-term care facility with the exception of payment for private room accommodations. No additional payment will be made to the hospice for negotiated private room rates. No retroactive adjustments are available for charges in the Medicaid rate made subsequent to the payment of room and board. Adjustments may be made to correct errors in billing.
- B. If a recipient has a recipient liability, the amount will be shown on a remittance advice. The hospice is responsible for collection of this amount from the recipient. The hospice may make arrangement with the long-term care facility to collect the recipient liability. The department will not reimburse the hospice for any uncollected recipient liability.

### **Billing Procedures**

- A. A hospice claim must be submitted for all individuals electing hospice who are Medicaid eligible even if no payment is due from Medicaid and payment is made entirely by Medicare, insurance or other payment source.
- B. Hospice services and room and board charges must be billed on a UB-92. If billing more than one level of care, a separate bill may be prepared each time the level of care changes during the hospice's billing period. A billing period is defined as a calendar month or a portion of a calendar month.
- C. The following information must be completed to bill for hospice services. For additional instructions on completion of the UB-92, refer to the UB-92 procedure manual.

**Box 1**            Enter the name of the hospice provider as identified by the department.

**Box 4**            Enter the bill type.

- Box 6** Enter the period covered by the claim. Period can be for any or all of a month, but cannot be for more than one month.
- Box 7** Enter the number of covered days. Days must agree with the dates entered in Box 6
- Box 12** Enter the recipient's full name as identified by the department.
- Box 13** Enter address where hospice services were provided. If services were provided in an inpatient facility or long term care facility, enter the facility name instead of the address.
- Box 17** Enter admission data.
- Box 19** Enter admission data.
- Box 20** Enter admission data.
- Box 22** Enter patient status as follows: **Please note the patient status codes are only to be used when a hospice patient resides in a nursing facility.**

Blank	means, "still a patient"
0	means, "reserved bed days"
1	means, "transferred to a hospital"
2	means, "transferred to another LTC facility"
4	means, "reserved bed days – patient deceased"
5	means, "discharged to home/self care"
6	means, "discharged to home/HHA"
7	means, "left against advice"
8	means, "deceased"
9	means, "patient on therapeutic leave"

- Box 42** Enter appropriate Revenue Code as follows:

651 – Routine Home Care – per day  
 652 – Continuous Home Care – per hour  
 655 – Inpatient Respite Care – per day  
 656 – General Inpatient Care – per day  
 657 – Hospice Physician Service – CPT  
 659 – Other Hospice (Room and Board in a nursing facility) – calculated rate

- Box 43** Enter the description of the revenue code or procedure.

- Box 46** Enter the number of units that corresponds to the date span in Box 6. For revenue codes 651, 655, 656 and 659, each unit equals one day. For revenue code 652, each unit equals one hour. For revenue code 657, each unit equals the number of CPT units performed by the hospice physician.



- Box 47** Enter the total charges. This must equal the Medicaid rate payable time the Number of units. The rates for nursing facilities should be obtained from the long term care facility.
- Box 51** Enter the hospice's Medicaid provider number.
- Box 54** Enter any insurance payments.
- Box 55** Enter the total amount due from amounts listed in Box 47.
- Box 60** Enter the recipient's Medicaid identification number.
- Box 67** Enter the principal and secondary diagnosis codes.
- Box 82** Enter the attending physician's UPIN.
- Box 85** Sign the claim.
- Box 86** Date the claim.